

# Arizona State Board of Pharmacy

623-463-ASBP(2727). FAX: 623-934-0583

[www.pharmacy.state.az.us](http://www.pharmacy.state.az.us)

(Call Board Office for Fee Information)

1. Business name: \_\_\_\_\_
  2. Address: \_\_\_\_\_  
                        Street and Number   City   State   Zip
  3. Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ E-mail: \_\_\_\_\_
  4. Mailing address if different: \_\_\_\_\_  
                                    Street and Number   City   State   Zip
  5. Name of owner(s): \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_  
If corporation or partnership, attach a list officers or partners on a separate sheet, including name, title and address.
  6. Date business started/opening: \_\_\_\_\_ Type of business: \_\_\_\_\_
  7. This application submitted because of change in ownership? No \_\_\_\_\_. Yes \_\_\_\_\_. If yes; give former owner's name, AZ permit number, and permit name (if different) \_\_\_\_\_
  8. Other trade or business names used: \_\_\_\_\_
  9. Have you conducted a similar business in any other jurisdiction?  
No \_\_\_\_\_. Yes \_\_\_\_\_. If yes, state under what names, locations and permit number:  
\_\_\_\_\_
  10. Has the owner, or any corporate officer or active partner ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and is so indicate charge, conviction date, jurisdiction, and location:  
\_\_\_\_\_
  11. Has the owner, any corporate officer or active partner ever been denied a drug manufacturer permit in this state or any other jurisdiction? No \_\_\_\_\_. Yes \_\_\_\_\_. If yes, indicate where and when:  
\_\_\_\_\_
  12. a) FDA drug manufacturer or repackager registration. List current number and expiration date: \_\_\_\_\_  
b) FDA drug list. Include copy of drug list required by FDA.
  13. FACILITIES LOCATED IN ARIZONA the following is required:  
a) Floor plan. Include plans or construction drawing showing facility size and security adequate for the proposed business.  
b) Zoning. Include documentation of compliance with local zoning laws.  
c) Name of pharmacist-in-charge: \_\_\_\_\_  
AZ Lic #: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Emergency phone: \_\_\_\_\_  
d) The persons named in Number 13(c) & 15 will be present at the Arizona State Board of Pharmacy meeting when application is submitted for approval.
  14. FACILITIES LOCATED OUTSIDE OF ARIZONA: Attach a photo copy of license/permit issued by State of domicile.
  15. Name of manager or responsible person: \_\_\_\_\_ Emergency phone: \_\_\_\_\_
- Home address: \_\_\_\_\_  
                        Street and Number   City   State   Zip
- On separate document: Resume indicating educational or experiential qualifications related to drug manufacturing/repackaging operations.

To the best of my knowledge and belief the foregoing application is true and current in all respects.

Signature of Owner, Corporate Officer or Manager

**Title**

Date \_\_\_\_\_